COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult 3-Month (3M)

Age Group: 60+

ADMINISTRATIVE INFORMATION

Client ID		Client DOB	
Episode ID		Provider Number	(4 characters)
Client Last Name		Client First Name	
Partnership Date		Assessment Date	
Partnership Service Coordinator (Last Name)		Assessment Completed By	(10 characters NPI #)

FINANCIAL

SOURCES OF FINANCIAL SUPPORT Indicate all the sources of financial support used to meet the needs of the client.	**CURRENT**	
	Check all that apply	**Monthly Average Amount**
Client's Wages	☐	
Client's Spouse / Significant Other's Wages	☐	
Savings	☐	
Other Family Member / Friend	☐	
Retirement / Social Security Income	☐	
Veteran's Assistance (VA) Benefits	☐	
Loan / Credit	☐	
Housing Subsidy	☐	
General Relief (GR) / General Assistance (GA)	☐	
Food Stamps	☐	
Temporary Assistance for Needy Families (TANF) / CalWORKs	☐	
Supplemental Security Income / State Supplementary Payment (SSI / SSP) Program	☐	
Social Security Disability Insurance (SSDI)	☐	
State Disability Insurance (SDI)	☐	
American Indian Tribal Benefits (e.g., per capita, revenue sharing, trust disbursements)	☐	
Unemployment	☐	
Child Support	☐	
Other	☐	
No Financial Support	☐	

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Name | IS#

Agency | Provider #

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

INDEX OF INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

For each area of functioning listed below, check the description that applies:
(The word 'assistance' means supervision, direction or personal assistance).

Bathing - either sponge bath, tub bath or shower: **(select one)**

- ◯ Receives no assistace (gets in and out of tub by self, if tub is usual means of bathing).
- ◯ Receives assistance in bathing only one part of the body (such as back or leg).
- ◯ Receives assistance in bathing more than one part of the body (or not bathed).

Dressing - gets clothes from closet or drawers, including underclothes, outer garments and uses fasteners (including braces, if worn): **(select one)**

- ◯ Gets clothes and gets completely dressed without assistance.
- ◯ Gets clothes and gets completely dressed without assistance, except for assistance in tying shoes.
- ◯ Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed.

Toileting: **(select one)**

- ◯ Goes to 'toilet room', cleans self, and arranges clothes without assistance (may use object to support such as cane, walker, or wheelchair and may manage night bed pan or commode, emptying same in AM).
- ◯ Receives assistance in going to the 'toilet room' or in cleansing self or in arranging clothes after elimination or in use of night bed pan or commode.
- ◯ Doesn't go to room termed 'toilet' for the elimination process.

Transfer: **(select one)**

- ◯ Moves in and out of bed as well as in and out of chair without assistance (may be using object for support, such as cane or walker).
- ◯ Moves in and out of bed or chair with assistance.
- ◯ Doesn't get out of bed.

Continence: **(select one)**

- ◯ Controls urination and bowel movement completely by self.
- ◯ Has occasional 'accidents'.
- ◯ Supervision helps keep urine or bowel control; catheter is used, or person is incontinent.

Feeding: **(select one)**

- ◯ Feeds self without assistance.
- ◯ Feeds self except for getting assistance cutting meal or buttering bread.
- ◯ Receives assistance in feeding or is fed partly or completely by using tubes or I.V. fluids.

Walking: **(select one)**

- ◯ Walks on level without assistance.
- ◯ Walks without assistance but uses a single, straight cane.
- ◯ Walks without assistance but uses two points for mechanical support such as crutches, a walker, or two canes (or wears a brace).
- ◯ Walks with assistance.
- ◯ Uses wheelchair only.
- ◯ Not walking or using wheelchair.

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DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

House-Confinement: **(select one)**

- ◯ Has been outside of residence 3 or more days DURING THE PAST 2 WEEKS.
- ◯ Has been outside of residence only 1 or 2 days DURING THE PAST 2 WEEKS.
- ◯ Has not been outside of residence IN THE PAST 2 WEEKS.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

For each area of functioning listed below, select the description that applies:	Without Help	With Some Help	Completely Unable To Do
Can the client use the telephone?	◯	◯	◯
Can the client get to places out of walking distance?	◯	◯	◯
Can the client go shopping for groceries?	◯	◯	◯
Can the client prepare his/her own meals?	◯	◯	◯
Can the client do his/her own housework?	◯	◯	◯
Can the client do his/her own handyman work?	◯	◯	◯
Can the do his/her own laundry?	◯	◯	◯
If the client takes medication (or if the client had to take medication) could he/she take it on his/her own?	◯	◯	◯
Can the client manage his/her own money?	◯	◯	◯

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PHYSICAL HEALTH

	CURRENT (LAST 4 WEEKS) (select one for each question)
Client states that he/she is in good physical health?	Yes No
Client has access to needed medical services?	Yes No
Client receives needed medical services?	Yes No
Client has a primary care physician?	Yes No
Client uses a primary care physician?	Yes No
Client has access to needed dental services?	Yes No
Client receives needed dental services?	Yes No
Client demonstrates signs of regressive behavior (bed wetting, soiling)?	Yes No
Client demonstrates self-injurious behavior?	Yes No
Client has violent encounters?	Yes No
Client has a caretaker relationship?	Yes No
Is the caretaker a paid In-Home Worker?	Yes No
Is the caretaker a paid Supported Transitional Worker?	Yes No
Is the caretaker a significant other?	Yes No
Is the caretaker a family member?	Yes No
Is the client obese (based on BMI)?	Yes No
Has the client EVER been told by a physician that he/she has diabetes?	Yes No

Based on the Mini Mental Status Exam (MMSE), the client presented with symptoms of cognitive impairment? Yes No

If yes, what level? **(select one)**

- Mild
- Moderate
- Severe

Based on the Confusion Assessment Method (CAM) the client presented with symptoms of delirium? Yes No

If yes, identify the most appropriate: **(select one)**

- Acute Change
- Altered Level of Consciousness
- Disorganized Thinking
- Inattention

Based on the Geriatric Depression Scale (GDS), the client presented with depressive Symptoms? Yes No

Did the client receive physical health services from a DHS clinic or hospital? Yes No

Does the client have a chronic physical health care problem or problems that require periodic medical services? Yes No

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LEGAL

SUBSTANCE ABUSE

Client uses substances?	Yes	No
Client abuses substances?	Yes	No
In the opinion of the Partnership Service Coordinator, does the client CURRENTLY have an active co-occurring mental illness and substance use problem?	Yes	No
Is the client CURRENTLY receiving substance abuse services?	Yes	No

CUSTODY INFORMATION

Indicate the total number of children the **client** has who are CURRENTLY:
(If the client has no children enter **0** in the following boxes.)

Placed on W & I Code 300 Status (Dependent of the court):	
Placed in Foster Care:	
Legally Reunified with the client:	
Adopted Out:	
Living with the client:	

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